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BRIEF FOR THE RESPONDENTS AMERICAN NURSES ASSOCIATION, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS, AND THE BUILDING AND CONSTRUCTION TRADES DEPARTMENT, AFL-CIO

This brief is submitted jointly on behalf of the three union respondents in this case: the American Nurses Association, the American Federation of Labor and Congress of Industrial Organizations ("AFL-CIO"), and the Building and Construction Trades Department of the AFL-CIO. The union respondents accept the statement of the opinions below, the statement of jurisdiction, and the statement of the statutory provisions involved contained in the brief of petitioner American Hospital Association. And to avoid duplicative submissions, the union respondents leave it to the respondent National Labor Relations Board, whose position in this matter we fully support, to state the case for the Court.

SUMMARY OF ARGUMENT

I. The brief of the National Labor Relations Board ("NLRB" or "the Board") demonstrates that petitioner American Hospital Association ("AHA") misunderstands § 9(b) of the National Labor Relations Act, as amended, insofar as the AHA contends that the section commands the Board to base its unit decision on "individual case-by-case evaluation." We show that the AHA equally misunderstands the nature of the decisions the Board is called upon to make under § 9, and that the AHA's "case by case" approach would lead to a regime which would defeat the policies of the Act. Pp. 3-21 *infra*.

Under § 9 the NLRB decides whether a proposed grouping of employees is an appropriate predicate for collective bargaining. Such determinations can logically be made across an industry based upon considerations that do not vary from case to case; for example, jobs

can be grouped into units based upon the functions the jobs entail and the training and skills required to perform the jobs. That is precisely what the Board did here.

Furthermore, the policies of the Act demand that unit determinations be made across an industry. The electorial system the NLRA creates could not work if the boundaries of the election unit had to be decided anew in each case based on employer-specific considerations. And, the ability of employees to eliminate wage competition through collective bargaining would be effectively nullified if, within a given labor market, unit configurations varied from employer to employer.

II. The admonition regarding unit "proliferation" contained in the committee reports accompanying the 1974 Health Care Amendments does not provide an independent basis for overturning the Rule. Congress made a deliberate decision in 1974 not to legislate with respect to hospital unit determinations; the fair inference, therefore, is that Congress did not intend to disturb the Board's preexisting discretionary authority in this regard. Moreover, regardless of what the 1974 Congress may have thought regarding unit determinations, its views are entitled to no weight in determining the Board's legal obligations because that Congress failed to translate its sentiments into positive law. The views expressed in the admonition do not illuminate the statutory text but at most state a consideration which a subsequent Congress wished—but did not mandate—the Board to "consider" in a category of cases. Pp. 21-36 *infra*.

III. The Board did not act arbitrarily or capriciously in promulgating a rule that applies to acute care hospitals generally. The rulemaking record establishes that such hospitals share many characteristics in common; most importantly, in such hospitals there are discrete functions which require discrete sets of skills and training and which are performed by discrete groups of

employees. These considerations do not vary based on the size, location, or particular mix of services provided by a hospital. Indeed, when all is said and done, the AHA fails to offer even a single instance in which the findings underlying the Rule do not apply, let alone any cogent demonstration that the Rule's generalizations are so off-target as to be arbitrary and capricious. Pp. 37-50 *infra*.

ARGUMENT

Introduction

This case is about appropriate bargaining units in acute care hospitals, and about the authority of the National Labor Relations Board ("NLRB" or "the Board") to define such units by general rule. But to state the issues in these terms obscures as much as it reveals.

As Professor Gorman has observed, the term "bargaining unit" is something of a misnomer. Because "employees represented in different . . . units may choose to 're-group' as a single larger entity for purposes of conducting actual negotiations," the "composition of the *negotiating* unit will . . . frequently depend less upon the Board's unit determination than upon the structure of the employer and the union and upon alliances among employees or unions." R. Gorman, *Basic Text on Labor Law* 66 (1976) (emphasis in the original).[1]

The real significance of the NLRB's "bargaining unit" determinations is, as Professor Gorman states, to define the "*election* unit" within which representation elections take place. *Id.* (emphasis in the original). Herein lies the heart of this case, for inevitably unit determinations profoundly influence election outcomes. As Judge Posner explained in his opinion below:

> This is because the smaller and more homogenous a bargaining unit is, the easier it will be for the mem-

[1] *See also* J.A. 89-90 (describing experience in New York hospitals).

> bers to agree on a mutually advantageous course of collective action, and therefore the more attractive a union will be . . . By the same token, the larger and more heterogeneous the unit is the harder it will be for the members to agree on a common course of action. [Pet. App. 3a [2]]

In promulgating the Rule which is at issue here, the NLRB—after finding that grouping all professional or all non-professional hospital employees in a single unit "would result in too diversified a constituency," J.A. 61; *see id.* at 88-91—set about to identify a "reasonable number of units that will realistically reflect pronounced natural groupings to be found in health care facilities," J.A. 67.

The rulemaking record persuaded the Board that among professional hospital employees two groups—physicians and registered nurses—possess "truly distinctive interests and concerns," J.A. 191, which justify allowing each of these groups to organize on a separate basis, (although, as the Board noted, many hospital physicians are "independent contractors" and are precluded from organizing for that reason, *see* J.A. 251). Among nonprofessional hospital employees the Board found three such "natural groupings"—medical technicians, business office clericals, and skilled maintenance craft employees.

The record further persuaded the Board that these groups—plus a residual all-other professional group, a

[2] Robert Muehlenkamp, Executive Vice President of the National Union of Hospital and Health Care Employees, put it this way in his testimony before the Board in the rulemaking proceeding:

> What I think we are talking about is whether or not there will be voting groups such that those . . . who see that they have more separating them than they have in common will be put together into voting groups so that those who do want to participate in collective bargaining are deprived of the right, and those that did not want to be involved in the process at all . . . destroy the opportunity for those who . . . wanted to engage in collective bargaining. [Tr. 4759]

residual all-other nonprofessional group and a guards group as required by the Act [3]—will

> not be so large that organizing them is exceedingly difficult and representing them even harder because of inherent conflicts of interest within the groups; but large enough that unnecessary, repetitious rounds of bargaining are avoided along with such undesirable results as frequent strikes, wage whipsawing, and jurisdictional disputes. [J.A. 67 [4]]

Accordingly, the Board adopted the Rule which provides that absent "extraordinary circumstances," employees in any one of the five groups identified by the Board (or in one of the residual groups) may elect to organize as a separate unit, but that no other subgroup of professionals or non-professionals may do so.

Significantly, the brief of petitioner American Hospital Association ("AHA"), does *not* challenge either the Board's finding that each of these units represents a "natural grouping" with "truly distinctive and concerns" or the Board's finding that these units are sufficiently broad and functionally distinct as not to beget whipsawing or labor unrest. Instead, in a variety of timbres and in a

[3] Section 9(b)(3) of the National Labor Relations Act, as amended, 29 U.S.C. § 159(b)(3), mandates a separate unit for guards which unit cannot be represented by any union that represents any non-guards employed by any employer in any industry. In practice, such units are "rarely sought." J.A. 193.

[4] In reaching this latter conclusion, the Board drew upon a wealth of empirical evidence presented in the rulemaking concerning the actual bargaining experience in the various units proposed by the Board. That evidence included studies of the thousands of hospital collective bargaining agreements negotiated since the 1940's by the Service Employees International Union, the National Union of Hospital and Health Care Employees, and the International Union of Operating Engineers and a study of all the hospital collective agreements—some 7,431—which, according to Federal Mediation and Conciliation Service records, were negotiated in any organized hospital during the three years preceding the rulemaking hearings. *See* WS Gerry Shea, pp. 1-2; IUOE Ex. 2 (revised); AFL-CIO Exs. 5-6.

number of keys, the AHA sounds but a single note: the NLRB is without the legal authority to identify groupings of employees which ordinarily will constitute appropriate units in an acute care general hospital.

According to the AHA, § 9(b) of the National Labor Relations Act, as amended, 29 U.S.C. § 159(b) ("NLRA" or "the Act"), prohibits this approach and demands "individual, case-by-case bargaining unit determinations." AHA Br. at 16; *see id.* at 13-25. So, too, does the Health Care Amendment Act of 1974, P.L. 93-360 ("the 1974 Amendments"). *See* AHA Br. at 26-38. And in any event, says the AHA, "it was folly for the Board even to try to develop a rule that would designate specific bargaining units . . . because the great diversity in the industry makes such an approach inherently arbitrary and capricious." AHA Br. at 40.

In the sections that follow, we treat with each of these contentions in turn. Before doing so, however, one preliminary observation is in order.

If either NLRA § 9(b) or the 1974 Amendments have the effect of prohibiting the Board from "particularizing statutory standards through the rulemaking process," *FPC v. Texaco*, 377 U.S. 33, 39 (1964), these are singular—and suspect—statutes indeed. The rule of law is, as Justice Scalia has argued in his Holmes lecture, a "law of rules," Scalia, *The Rule of Law as a Law of Rules*, 56 U. CHI. L. REV. 1175 (1989), and not an institutionalization of the "kadi under a tree dispensing justice according to considerations of individual expediency," *Terminiello v. Chicago*, 337 U.S. 1, 11 (1949) (Frankfurter, J., dissenting). Thus, as Holmes himself told us, "the tendency of the law must always be to narrow the field of uncertainty." O. W. Holmes Jr., *The Common Law* 127 (1881).

Administrative agencies provide a working mechanism for reaching that goal. The genius of our administrative law system, as the late Judge Friendly observed, is that it enables an expert body to take a general statutory standard—such as § 9(b)'s requirement that each bar-

gaining unit be "an appropriate unit"—and to "define and clarify it—to canalize the broad stream into a number of narrower ones . . . to the point of affording a fair degree of predictability of decision in the great majority of cases." Friendly, *The Federal Administrative Agencies: The Need for Better Definition of Standards*, 75 HARV L. REV. 863, 874 (1962). Administrative agencies, no less than courts, are thus charged with the task of "isolating facts pertinent to all the cases which may form the basis for a rule." *Id.* at 877.

For many years—indeed until this very case—the AHA saw the Labor Board's task in defining appropriate bargaining units in these classic terms. Thus, when the Board, after acquiring jurisdiction over non-profit hospitals in 1974, extended comity to unit determinations which had been made by state administrative agencies prior to the 1974 Amendments, the AHA complained to the courts of appeals that the Agency was frustrating "Board development of a *uniform national approach to* appropriate units in the . . . health care industry."[5]

Moreover, when the NLRB began making its own hospital unit determinations and vacillated in its treatment of the skilled maintenance employees, the AHA protested that

> The absence of uniformity in these decisions serves to generate confusion as to where maintenance employees belong or will be placed in future cases. *One of the functions of case law, including administrative case law, is the predictability and precedent that it secures. The Board's maintenance unit decisions do not serve this important goal.*[6]

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[5] Brief for the AHA as Amicus Curiae in *Memorial Hospital of Roxborugh v. NLRB*, C.A. No. 75-2198 (3rd Cir. 1976), p. 14 (emphasis added); Brief for the AHA as Amicus Curiae in *Long Island College Hospital v. NLRB*, C.A. No. 77-4038 (2nd Cir. 1977), p. 16 (emphasis added).

[6] Brief for the AHA as Amicus Curiae in *St. Vincent's Hospital v. NLRB*, C.A. No. 77-1027 (3rd Cir. 1977), pp. 4-5 (emphasis added); Brief for the AHA as Amicus Curiae in *NLRB v. West*

And in the lead hospital bargaining unit prior to the promulgation of the Rule, the AHA urged the Board to declare an all-professional unit and an all non-professional unit to be the "primary bargaining units" for *all* hospitals and to require "*extraordinary and compelling circumstances*" to justify variations from these units.[7]

It is not difficult to understand why the AHA no longer sees virtue in "uniform[ity]" and "predictability," and now disdains a hospital bargaining unit rule which denominates "primary units" and applies in all but "extraordinary" cases (as the AHA once urged). For the rulemaking record makes quite clear that the "individual case-by-case" approach the AHA now champions has substantially prolonged the process of making unit determinations and to that extent has served well the interests of the hospitals which desire to frustrate employee organization.[8] In contrast, the Rule the NLRB has promulgated is designed to further *Congress'* intent in enacting the 1974 Amendments which was, as this Court has observed, to "overcome the poor working conditions retarding the delivery of quality health care" through "extension of organizational and collective-bargaining rights" to health care employees. *Beth Israel Hospital v. NLRB*, 437 U.S. 483, 498, 500 (1978).

As we proceed to show—and as the AHA itself once recognized—nothing in the NLRA, the 1974 Amendments, or the nature of the hospital industry precludes the Board from "canaliz[ing] the broad stream" of § 9 into "narrower ones" by identifying groupings of em-

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Suburban Hospital, C.A. No. 77-1340 (7th Cir. 1978), pp. 2-3 (emphasis added).

[7] Brief Amicus Curiae on Behalf of the American Hospital Association in *St. Francis Hospital, Inc.*, NLRB Case No. 26-CA-10060, pp. 19-20 (emphasis added).

[8] *See* WS Profs. Delaney & Sockell, p. 23. *See also* Note, *The National Labor Relations Board's Proposed Rule on Health Care Bargaining Units*, 76 U. VA. L. REV. 115, 151-52 (1990).

ployees which, absent extraordinary circumstances, constitute appropriate hospital bargaining units.

I. THE NLRB CORRECTLY, AND IN ALL EVENTS RATIONALLY, INTERPRETED NLRA SECTION 9(b) TO PERMIT THE BOARD TO BASE ITS UNIT DECISIONS ON RULES OF GENERAL APPLICABILITY.

In its initial Notice of Proposed Rulemaking, J.A. 15-19, in the second Notice of Proposed Rulemaking, J.A. 46-47, and in the Preamble to the Final Rule, J.A. 211-17, the NLRB carefully considered its authority to delimit bargaining units by general rule and concluded that, as Professor Kenneth Davis has argued (along with many other commentators):

> The mandate to decide "in each case" does not prevent the Board from supplanting the original discretionary chaos with some degree of order, and the principal instruments for regularizing the system of deciding "in each case" are classifications, rules, principles, and precedents. Sensible men could not refuse to use such instruments and a sensible Congress would not expect them to. [K. Davis, *Administrative Law Text* 145 (3rd ed. 1972), *quoted in* J.A. 16, 47]

Ignoring completely the deference owed to the NLRB's interpretation of the Act it administers, *e.g.*, *NLRB v. Food & Commercial Workers*, 484 U.S. 112, 123 (1988), the AHA argues that the Board misconstrued § 9(b). According to the AHA's present position, the command to the Board to render unit decisions "in each case" is a command that the Agency base its unit decisions on "individual case-by-case evaluation," AHA Br. at 19, "taking into account the circumstances of the particular hospital," AHA Br. at 47. Indeed, according to the AHA, determining whether a bargaining unit is appropriate is analogous to assessing the "individual abilities" of a claimant for disabilities benefits in that, in the AHA's view, both types of determinations "involve[] . . . matters of historic fact, unique to each [case]." AHA Br. at 22.

Thus, according to the AHA, while the Board may "adopt rules establishing general principles to guide the required case-by-case bargaining unit determinations" such as rules "stating the factors regional directors should weigh," the NLRB is precluded from formulating rules of decision which are inconsistent with "[s]ection 9(b)'s requirement of meaningful, case-by-case bargaining unit determination." AHA Br. at 19, 20.

It is important to be clear as to the full sweep of the AHA's argument. Most obviously, the AHA reads § 9(b) as a "specific exception" to, AHA Br. at 25—and limitation upon—the Board's authority under NLRA § 6, 29 U.S.C. § 156, "to make . . . such rules and regulations as may be necessary to carry out the provisions of this Act." In the AHA's view, notwithstanding § 6's *unlimited* grant of rulemaking authority, the NLRB may not promulgate rules defining particular groupings of employees as appropriate units.

Moreover, as Judge Posner observed in his opinion below, the AHA's argument would apply equally "if the Board had announced the rule in an adjudicative proceeding." Pet. App. 8a. Thus, acceptance of the AHA's position would require overturning countless NLRB decisions delimiting appropriate units for an industry or for a subgroup of employers within an industry. *See* n.12 *infra*. Indeed, the logic of the AHA's position would prevent the Board from formulating any rules which apply beyond a single case, because § 9(b), in the AHA's view, mandates "individual case-by-case evaluation."

In its brief, the NLRB shows that the AHA profoundly misunderstands § 9(b). The AHA's interpretation of "in each case" is not a necessary—or even a plausible—reading of the statutory text as that language does *not* purport to address the *source of law* which is to be applied "in each case." The AHA's interpretation is even more implausible in light of the legislative history which shows that the point of the "in each case" language was "to prevent the Board from bringing about

a revolution in unit determinations by prescribing employer units, or craft units, or plant units for all employers under the Board's jurisdiction." Pet. App. 6a-7a. And the AHA's understanding of § 9(b) is at war with the manner in which the Act has been interpreted and applied for the better part of five decades as well as with the teaching of this Court in *Labor Board v. Metropolitan Ins. Co.*, 380 U.S. 438 (1963).

The Board's arguments are, of course, fully dispositive of the AHA's contention. But, as we proceed to demonstrate, the AHA's argument suffers from a second and equally fatal flaw: that argument profoundly misunderstands the nature of the decisions the Board is called upon to make under § 9. Indeed—as the AHA itself once recognized, pp. 7-8 *supra*—the AHA's argument would lead to a regime which, in practice, would defeat the policies the Act is designed to further. For these reasons, too, the AHA's argument should be rejected.

1. The AHA's reliance on § 9(b) is ultimately circular. The AHA concedes, as it must, that statutory provisions like § 9(b) which require hearings or decisions "in each case" do not foreclose an administrative agency from "rely[ing] on its rulemaking authority to determine issues that do not require case-by-case consideration." *Heckler v. Campbell*, 461 U.S. 458, 467 (1983); *see* AHA Br. at 21. As the Court explained in *Heckler*, "[a] contrary holding would require the agency continually to relitigate issues that may be established fairly and efficiently in a single rulemaking proceeding." *Id.*

It necessarily follows that § 9(b) cannot answer the question whether unit determinations require "case-by-case consideration" or whether those determinations can be "established fairly and efficiently in a single rulemaking proceeding." That answer depends at the threshold on the nature of the issues that must be resolved to define appropriate units. The AHA's submission at bottom rests on its posit that "[*b*]*y their nature*" unit deter-

minations—like assessments of individual abilities—"require case by case consideration" because such determinations necessarily turn on "matters of historic fact, unique to each hospital." AHA Br. at 22 (emphasis added). As we proceed to show, the Board acted well within its discretion in reaching a contrary conclusion.

2. NLRA § 9(a), 29 U.S.C. § 159(a), provides in pertinent part that "[r]epresentatives . . . selected for the purposes of collective bargaining by the majority of the employees in a unit appropriate for such purposes shall be the exclusive representatives of all the employees in such unit." Section 9(b), in turn, directs the Board to "decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this Act, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof." And § 9(c), 29 U.S.C. § 159(c), then provides a procedure whereby a "group of employees . . . [who] wish to be represented for collective bargaining" (or an employer who has received a claim for recognition from his employees) may petition the NLRB to hold a representation election within an appropriate unit.

Under this statutory scheme the question the NLRB must decide in any given representation proceeding is whether, "in order to assure to employees the fullest freedom in exercising the[ir] rights," the grouping of employees which is seeking representation should be deemed to constitute "a unit appropriate" for the "purpose of collective bargaining." The Board's "focus is on whether the employees share a 'community of interest'" as "[a] cohesive unit—one relatively free of conflicts of interest—serves the Act's purpose of effective collective bargaining and prevents a minority interest group from being submerged in an overly large unit." *NLRB v. Action Automotive, Inc.* 469 U.S. 490, 494 (1985); *see Chemical Workers v. Pittsburgh Glass*, 404 U.S. 157, 172 (1971).

Of particular significance, the Act demands only that the Board determine whether a proposed unit is "*an* appropriate unit." As the Board has long recognized:

> Appropriate is a word with a well-defined meaning. . . . It carries with it no overtones of the exclusive or the ultimate or the superlative. To convey such thoughts, the words "only" or "ultimate" or "most" must be conjoined with the word "appropriate." [*Morand Brothers Beverage Co.*, 91 NLRB 409, 418 n.13 (1950), *enf'd*, 190 F.2d 576 (7th Cir. 1951)]

Given the substance of the question the Board is called upon to decide, the AHA is simply wrong in contending that unit determinations must, of necessity, turn on "matters of historic fact, unique to each hospital." AHA Br. at 22. Such historic fact would quite obviously be determinative if the Board were required to fashion the *optimal* unit in each case, as that could not be done without a detailed and case-specific assessment of all the facts and circumstances pertaining to a particular employer. But as *Morand Brothers* teaches, "There is nothing in the statute which requires that the unit for bargaining be the only appropriate unit, or the ultimate unit, or the most appropriate unit; the Act requires only that the unit be 'appropriate.'" 91 NLRB at 418; *see also, e.g.*, R. Gorman, *Basic Text on Labor Law*, *supra*, at 66; C. Morris (ed.), *The Developing Labor Law* 414 (2d ed. 1983).

The much broader § 9 standard the Board actually is called upon to administer—determining whether a particular grouping of employees is sufficiently "cohesive" to make that grouping an appropriate predicate for collective bargaining—does not require the same degree of particularity in decision-making. Such determinations can logically be based upon considerations that do not vary from case to case; for example, jobs can be grouped into units based upon the functions the jobs entail and the training and skills that are required to perform the jobs. And although facts specific to an em-

ployer may make a particular unit more or less appropriate in a particular case, such facts are unlikely, except in the extraordinary case, to render a "functionally distinct" unit, *Chemical Workers v. Pittsburgh Glass*, *supra*, 404 U.S. at 172, which is an appropriate unit in one workplace within an industry but inappropriate in another place in the same industry.

A few examples from the Rule itself help to make the point concrete. As previously noted, the Rule recognizes three groups of non-professionals as constituting appropriate units: medical technicians; office clericals; and skilled maintenance craft employees. As to each group, the Board found:

> (1) The group performs a unique set of tasks requiring unique training and skills. Medical technicians work in the various medical laboratories performing "routine clinical tests," J.A. 123-24; office clericals work in hospital business offices and "are primarily responsible for a hospital's financial and billing practices," J.A. 150-51; and the skilled maintenance craft employees are "engaged in the operation, maintenance, and repair of the hospital's physical plant systems." J.A. 133.
>
> (2) Within each group there are unique career paths: medical technicians may become professionals but they will not become secretaries, carpenters, plumbers or the like; business office clericals may leave the hospital industry for clerical work in another industry but they will not become technicians or craftsmen; and craftsmen move from apprentice to journeyman and from hospitals to other types of establishments, but they do not become technicians or secretaries. J.A. 128, 136-37, 155-56.
>
> (3) Each group has relatively limited contact with the other groups. Technicians work principally with the professionals in their laboratories and have little contact with the business office or the maintenance department. The skilled maintenance employees work on the physical plant and have only "brief, limited,

> and incidental" contact with other employees in the course of doing repair work. And the office clericals work within the business office which is physically isolated from the clinical units. J.A. 126, 136, 154-55.
>
> (4) While all the groups, and indeed, all employees, share concerns over wages and benefits, each of these groups also has a unique set of labor-related concerns arising out of their unique occupations and each group historically has organized on a separate basis. Maintenance employees, for example, seek "access to craft-related education and training programs; tool supply allowances; safety equipment and practices; [and] portable pensions"; office clericals are concerned with "pay equity, performance monitoring, productivity standards, . . . automation and VDT stress." J.A. 139-40; 157-58; *see* J.A. 129-31; 138-39; 156-57.
>
> (5) If permitted to organize separately, none of the groups is likely to develop jurisdictional conflicts with any of the other group as each group's jurisdiction is defined by the unique tasks the group performs. Nor is any of these groups likely to engage in "leapfrog" bargaining since each group has its own labor market and looks to the rate of pay within that labor market in making wage demands. J.A. 143-44, 158-59.

These considerations quite obviously are not case or employer specific; each applies across the industry and, except in an extraordinary case, is not susceptible of being rebutted on a case-by-case basis. And while the AHA complains bitterly that the Rule pretermits individualized decision making, the AHA fails to explain how, given these considerations, the "circumstances of the particular hospital," AHA Br. at 47, could, except in the extraordinary case, affect the appropriateness *vel non* of any of these three units. Thus, the Rule itself contains its own proof that the legal standard the Board is called upon to apply in unit determinations at the very least is susceptible of application across the industry.

3. Of equal importance, the policies of the Act *demand* that unit determinations be made across an industry. This is true for two independent reasons.

(a) The heart of the NLRA is the statutory protection granted to "the exercise by workers of full freedom of association, self-organization and designation of representation of their own choosing." NLRA § 1, 29 U.S.C. § 151. Towards that end, the Act creates the representation election procedure, described above, to facilitate employee self-determination.

The electoral system the NLRA seeks to create—like any other electoral system—presupposes an identifiable polity for whose support a campaign can be waged; the system could not work if, as the AHA supposes, the boundaries of the election unit had to be decided anew in each case based upon facts and circumstances "unique to each [employer]," p. 9 *supra*. In order for employees to be able to effectively exercise their right of self-organization they need to know when they begin their organizing campaign—and not months thereafter—which groupings of employees are (and are not) appropriate. Without such information the employees will not know who they must include (and who they may not include) in their organizing effort.[9]

By the same token, the administrative process would collapse of its own weight absent settled understandings

[9] This is especially true in light of the fact that, under the NLRA, the Board renders its unit determinations in response to representation petitions filed by a group of employees seeking collective bargaining representation. *See* NLRA § 9(c), 29 U.S.C. § 159(c). Such petitions must be accompanied by a "showing of interest" that at least 30% of the employees in the proposed unit have already designated a particular union to be their bargaining agent. NLRB Casehandling Manual, Part Two § 11022.3(a). And once a unit determination is made the Board will ordinarily direct an election within thirty days of the decision (provided, of course, that the union has made a sufficient showing of interest in the unit found to be appropriate). *See* C. Morris, *supra* 381. Thus the statutory scheme assumes that the organizing campaign will in large part *precede* any unit decision by the Board.

as to the scope of appropriate units. Section 9(c) requires that before filing a representation petition, a union must seek voluntary recognition from the employer of the affected employees. But if each unit determination were to turn on the unique historical circumstances of each individual case, employers and unions alike would be genuinely uncertain as to when particular types of units are (or are not) appropriate, and one party or the other would almost inevitably deem it worthwhile to litigate in the hopes of achieving a favorable decision (or tactical advantage from the litigation process itself).

The net effect of such a regime would be twofold. First, the Board's ability to procure settlements of representation disputes—which are the "life-blood of the administrative process" generally,[10] and which presently resolve 80% of all representation cases in particular—would be substantially diminished.[11] And second, if every contested representation case were to be treated as if the case posed a new problem to be solved by the Board *ab initio*—armed with nothing more than "general principles . . . stating the factors regional directors should weigh,"

[10] Attorney General's Committee on Administrative Procedure, *Administrative Proceedings in Government Agencies, Final Report*, S. Doc. 8, 77th Cong. 1st Sess. 35 (1941).

[11] *See* Tables 9 and 11B of the various Annual Reports of the National Labor Relations Board.

Indeed, when the 1974 Amendments were before Congress the Board testified that the Agency would be able to handle the volume of work because "[o]nce the Board sets the guidelines for jurisdiction and appropriate units, employers and unions will soon agree to consent elections in about 80% of the cases." *Hearings on H.R. 11357 Before the Subcomm. on Labor of the Senate Comm. on Labor and Public Welfare*, 92nd Cong. 2d Sess. 50-51 (1972) (hereinafter "1972 Hearings"). In fact, the rulemaking record shows that settlements have been less common in the hospital industry than other industries, at least in part because of the uncertainty that has existed as to what hospital units are appropriate. WS Prof. Schwartz, p. 10.

AHA Br. at 19—these cases would not only grow in numbers but also would become more and more difficult for the Board's many hearing officers to adjudicate. The ultimate result would be a much more costly and time-consuming representation procedure, one in which employee self-organization would become that much more difficult.

Thus, as the AHA once acknowledged, the representation procedure the Act creates requires the "predictability" and "uniformity," p. 7 *supra*, that rules—whether formulated through rulemaking or adjudication—provide.

(b) The policies of the Act also demand a consistency in unit determinations that can be achieved only through the application of more-or-less definite unit rules.

While the NLRA seeks to protect employee free choice, its more fundamental aim is, as § 1 of the Act declares, to "encourage the practice and procedure of collective bargaining." The "evil Congress was addressing" in enacting the NLRA was the "inequality of bargaining power" which exists when unorganized workers deal with their employer one by one, and "the resultant depressed wage rates." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 754 (1985). Congress hoped to overcome these "evils" by "establishing procedures for more equitable private bargaining." *Id.*

In order for collective bargaining to be effective in achieving these ends, "employees must make their combination extend beyond one shop" and include "as many as may be in the same trade in the same community" as workers are "bound to be affected by the standard of wages of their trade in the neighborhood." *American Steel Foundries v. Tri-City Trades Council*, 257 U.S. 184, 209 (1921). Thus, the labor laws state a "strong labor policy favoring the association of employees to eliminate competition over wages and working conditions." *Connell Co. v. Plumbers & Steamfitters*, 421 U.S. 616, 622 (1975).

Under the best of circumstances, that policy—which requires a high degree of organization within a given labor market—is difficult of effectuation. But the right of employees to eliminate wage competition through collective bargaining would be a nullity if unit configurations varied from employer to employer within a unit based upon the "unique historical circumstances" of each employer. Under such a regime medical technicians, to take one example, might constitute a separate unit in one hospital, might be combined in an all-nonprofessional unit in a second hospital, and might be conjoined with the skilled maintenance craftsmen in a third. The obstacles that would be posed to eliminating wage competition among the technicians in such a world are self-evident.

4. It is this complex of considerations that, as the NLRB demonstrates in its brief, has caused the Board, in industry after industry, after acquiring sufficient experience to understand the industry's workings, to announce rules defining particular groupings of employees in the industry as appropriate or inappropriate and to thereafter follow those rules in each succeeding case. There are, for example, rules governing basic manufacturing industries; rules for the construction industry; rules for retail establishments; and rules for more specialized industries such as newspapers, public utilities, and entertainment.[12]

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[12] For illustrations of these various rules *see, e.g., Chin Industries, Inc.*, 232 NLRB 176, 177 (1977) ("a production and maintenance unit normally constitutes an appropriate unit"); *Westinghouse Electric Corp.*, 118 NLRB 1043, 1047 (1957) ("it is contrary to Board policy to include office clericals in a production and maintenance unit"); *Armstrong Rubber Co.*, 144 NLRB 1115, 1119 (1963) ("the Board has consistently refused to join office and plant clerical employees in a single unit"); *Bulldog Electric Products Co.*, 96 NLRB 642, 643 (1951) ("the Board has repeatedly held that a unit of technical employees is appropriate"); *Astronautics Corp.*, 210 NLRB 650, 651 (1974) ("a unit of technical employees is inappropriate where it does not include all in that

Indeed as we discuss in great detail *infra* at pp. 23-30, the AHA's concern over "unit proliferation" when the 1974 Amendments were before Congress was fueled by rules that the Board had formulated on an industry-wide basis for certain other industries—rules which the AHA feared would be applied to the hospital industry as well. And the solution which the AHA unsuccessfully championed was to amend § 9(b) to fix certain units—which the NLRB had held to be appropriate in other industries—as the only appropriate for all health care institutions.

To be sure, in all other industries the Board has proceeded to define appropriate groupings of employees through adjudication rather than through rulemaking. That is in good measure because, as the Board explained in embarking upon this rulemaking proceeding, no agreed-upon first principles—that is, no accepted doctrinal test—had been developed to govern the health care industry that could serve as a base from which adjudication could proceed. *See* J.A. 5-11. But not even the AHA compains about the procedure the Board employed in this case. And as this Court has made clear "the choice between rulemaking and adjudication lies in the first instance within the Board's discretion," *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 194 (1974); *see also SEC v. Chenery Corp.*, 332 U.S. 194, 202 (1947) ("[t]o insist upon one form of action to the exclusion of the other is to exalt form over necessity").

5. One final point needs to be made. The AHA bases much of its attack on a claim that the Rule at issue here establishes "*conclusive presumptions* of law that apply."

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category"); *R.B. Buller, Inc.*, 160 NLRB 1595, 1598 (1963) ("in the construction industry, the Board has found separate units of craft employees to be appropriate"); *Garden Island Publishing Co.*, 154 NLRB 697 (1965) (newspaper industry); *Baltimore Gas & Electric Co.*, 206 NLRB 199 (1973) (utility industry). *See generally* Office of the General Counsel, *An Outline of Law and Procedure in Representation Cases* (1974).

AHA Br. at 12 (emphasis added). Our discussion to this point establishes that even if this were true, it would be of no legal consequence at least so long as the Board rationally determined that "acute care hospitals do not differ in substantial, significant ways relating to the appropriateness of units" and that "the policies of the Act would better be effectuated by the establishment of appropriate units" by rule. J.A. 189.

But the reality is that the AHA mischaracterizes the Rule; as the Board stated, "the rule does not . . . conclusively establish invariable parameters of bargaining units." J.A. 187. Rather, what the Board has done is to identify the recurring factual considerations that have led the Agency to conclude that each of the employee groupings provided for in the Rule is an appropriate bargaining unit; identify the recurring factual considerations which the Board has determined are insufficient to establish the inappropriateness of these units; and then leave it open to any hospital to prove (in any given case) that the particular hospital is so situated that application of the Rule would be "accidental or unjust." J.A. 187.

In other words, the Rule does leave room for case-by-case litigation, but only with respect to matters whose legal significance the Board has not yet addressed and found insufficient to impeach the appropriateness of the units the Board has delineated. And as we have seen nothing in § 9(b) forecloses the Board from promulgating such a rule.

II. THE 1974 AMENDMENTS DO NOT IMPOSE A LEGAL DUTY ON THE BOARD WHICH WOULD PRECLUDE THE BOARD FROM PROMULGATING ITS HOSPITAL BARGAINING UNIT RULE.

In promulgating the Rule, the NLRB considered at length the significance of the so-called "admonition" contained in the committee reports accompanying the 1974 Amendments which counsels the Board to give "[d]ue consideration . . . to preventing proliferation of bargaining units."

While questioning whether the admonition is legally binding, *see* J.A. 247-48, the Board concluded that in any event the Agency had satisfied the admonition by "carefully examining the exhaustive rulemaking record" and "mak[ing] a determination . . . consistent with a requirement that these units not be likely to produce the unwanted results of repeated work stoppages, jurisdictional disputes, wage whipsawing, and other related evils." J.A. 253; *see* J.A. 78-88, 110-13, 114, 131, 145-46, 158-59, 191-94, 246-54.

Notwithstanding the Board's careful attention to this issue, the AHA argues that the Agency has failed to satisfy the obligations created by the admonition. According to the AHA, the admonition requires the Board, before deciding whether any proposed hospital unit is an appropriate unit, to "determine the impact of [the] additional bargaining unit on [the] particular hospital," taking into account such factors as the "number of existing bargaining units" and whether "approval of th[e] unit is likely to lead to proliferation of units in the future." AHA Br. at 31-32 & nn. 14-15.[13] On this basis, the AHA contends that the admonition provides an independent basis for overturning the Rule.

We agree with the NLRB that the Agency complied with any legal requirement that could possibly be derived

[13] The AHA nowhere explains how the Board is to make such *predictive* judgments on a case-specific basis (other than to advance the remarkable suggestion that greater latitude should be afforded to the first group of employees in a hospital to organize than to any succeeding group). The reality is, as the Board observed in promulgating the Rule, that one of the advantages of rulemaking in this context is precisely to allow "past experience in the industry generally" to be considered in assessing the likely impact of upholding a proposed unit, "whereas under adjudication, whether strikes, whipsawing, or jurisdictional disputes will result if an initial organizing effort succeeds carries with it a greater degree of speculativeness" since "under adjudication of individual cases, no evidence whatever[in these regards] can be adduced as to the facility under considerations." J.A. 252.

from the legislative history of the 1974 Amendments. But it is our primary submission that, because the "admonition and the remarks addressed to it were divorced from the legislation then before Congress they are an illegitimate source of authority" for imposing obligations on the Board. *Electrical Workers Local 474 v. NLRB*, 814 F.2d 697, 717 (D.C. Cir. 1987) (Buckley, J., concurring).

Ironically, the best proof of the legal error that infects the AHA's submission lies in the legislative materials themselves. For once the legislative history is fully understood—and the half-truths and misstatements in the AHA's presentation of those materials corrected—it becomes readily apparent that the legislative history on which the AHA relies is not and cannot be a source of legal obligation. We thus begin with a detailed review of the legislative history of the 1974 Amendments and then address the legal significance of that history.

A. The Legislative Materials.

1. By the time the 1974 Amendments were being considered by Congress, there was a substantial body of experience and law with respect to the formulation of bargaining units in hospitals. The NLRA itself applied to proprietary or for-profit hospitals and nursing homes.[14] Moreover, thirteen states had elected to confer organizational rights on hospital employees as a matter of state law.[15] And there were even a few areas of the country—most notably California—in which, as of 1974, it was common for hospital employers, absent any legal requirement, to agree voluntarily to bargain collectively with their employees at the employees' request.[16]

[14] *See Butte Medical Properties*, 168 NLRB 266 (1967); *cf. University Nursing Homes*, 168 NLRB 263 (1967) (proprietary nursing homes).

[15] Federal Mediation and Conciliation Service, *Impact of the 1974 Health Care Amendments to the NLRA on Collective Bargaining in the Health Care Industry* 33 (1979).

[16] *See* 1972 Hearings at 157 (125 California hospitals have "had experience in collective bargaining" as of 1972).

Although many of the hospital bargaining units which were formed pre-1974 were of the type now permitted by the Rule, *see* J.A. 102-03, 129-30, 137-38, 156-57, there were a significant number of hospitals in which the employees had formed far narrower and more specialized units divided along professional, departmental, or craft lines. For example, the New York Labor Relations Board had recognized no less than 21 separate bargaining units for hospital employees including pharmacists, social workers, dieticians and "so on among the professionals, quasi-professionals and para-professionals found in hospitals."[17] In California there were similarly separate units for various professions, technical specialties (such as x-ray technicians, laboratory technicians, and vocational nurses), maintenance crafts (such as painters and engineers), and unskilled departments (such as kitchens, housekeeping and laundry units).[18] And the NLRB, in its pre-1974 decisions involving proprietary hospitals, had permitted separate units for various discrete professional and technical groups such as pharmacists, *Syosset General Hospital*, 190 NLRB 304 (1971), radiologic technologists, *Ochsner Clinic*, 196 NLRB 10 (1972), and LPNs, *Silver Lake Nursing Home*, 178 NLRB 478 (1969).

It was against this background that Congress considered the issue of appropriate units in the course of enacting the 1974 Amendments.

2. As the AHA observes, the 1974 Amendments were the culmination of a "legislative process that lasted two years." AHA Br. at 3. The proliferation issue was not injected into that process until after the House of Representatives had overwhelmingly approved a bill sponsored by Representatives (Frank) Thompson and (John)

[17] 1972 Hearings at 300.

[18] *Hearings on S. 794 Before the Subcommittee on Labor of the Senate Committee on Labor and Public Welfare*, 93rd Cong. 1st Sess. 199-200 (1973) (hereinafter "1973 Hearings").

Ashbrook, the chairman and ranking minority member of the House Special Labor Subcommittee, and backed by the Nixon Administration, *see* 1972 Hearings at 70-71, to extend the NLRA *in toto* to non-profit hospitals.

When that bill reached the Senate Labor Committee, the hospital industry, led by the AHA, mounted an eleventh-hour defense. The AHA argued that for two basic reasons, the NLRA was "inappropriate for application to the health care field." 1972 Hearings at 33 (testimony of David Hitt). "The first involves strikes, picketing and impasses. The second pertains to the fragmentation and proliferation of bargaining units." *Id.*

With regard to the latter objection, the AHA argued that the workforce of hospitals generally is divided into "over 100 separate occupational classifications with an overwhelming number being critical to the efficient operation of hospitals." *Id.* at 34. Referring specifically to the NLRB's proprietary hospital unit decisions, *see id.* at 35, the AHA argued that left unchecked the Board would follow the same rules throughout the hospital industry and allow separate units "for many other professional and paraprofessional groups as well as for the many crafts," *id.* at 35.[19]

The AHA's arguments sufficiently concerned Senator Robert Taft Jr. that the Senator blocked final action on the health care bill in the Ninety-Second Congress.[20]

3. When the Ninety-Third Congress convened in 1973, Representatives Thompson and Ashbrook reintroduced their bill to extend the NLRA to non-profit hospitals, and Senators Cranston and Javits introduced the identical bill

[19] *See also* 1972 Hearings at 155-56 (Minnesota Hospital Association), 169-71 (California Hospital Association), 208 (Texas Hospital Association), 238-39 (Ohio Hospital Association). It is noteworthy that neither the AHA nor any of its state affiliates had any difficulty in 1972 generalizing about the hospital industry or in discerning the general unit rules that apply in other industries.

[20] *Hospital Progress*, October, 1972, p. 21.

in the Senate. H.R. 1236, S. 794, 93rd Cong. 1st Sess. (1973), *reprinted in Legislative History of the Coverage of Nonprofit Hospitals Under the National Labor Relations Act, 1974* at 445, 448 (hereinafter "Leg. Hist."). Senator Taft introduced a separate bill to extend NLRA coverage to non-profit hospitals with amendments establishing special rules for such hospitals. S. 2292, 93rd Cong. 1st Sess., Leg. Hist. at 449-61. Thus, by the time the 1973 hearings began it was clear, as Senator Taft observed, that the "basic question" was no longer "whether coverage of the NLRA should be extended to non-profit hospitals" but rather whether and to what extent special provisions should be added to the Act to govern hospitals. 1973 Hearings at 75.

That being so, the AHA and all of the state hospital associations testifying in 1973 supported the Taft bill.[21] The Taft bill contained two provisions that were especially welcome to the hospital industry.

First, to deal with the issue of work stoppages which the AHA had raised, the Taft bill prohibited strikes in the health care industry during a mandatory four-month "cooling off period" following the expiration of every bargaining agreement, and the bill also made it unlawful for a health care union to strike or picket absent a secret ballot referendum vote authorizing such action. Second, to deal with the "proliferation" issue, the Taft bill fixed the appropriate bargaining units in health care institu-

[21] *See* 1973 Hearings at 143-49 (AHA proposal identical to Taft bill); 161 (Iowa Hospital Association); 169 (Colorado Hospital Association); 177 (Texas Hospital Association); 187 (California Hospital Association); 438 (New Jersey Hospital Association); 441 (Minnesota Hospital Association); 443 (Ohio Hospital Association).

The AHA is thus simply wrong in claiming in its brief to this Court that in 1973-74 "much of the industry opposed altogether any repeal of the exemption [of non-profit hospitals from the NLRA]," and in viewing the ultimate legislation that was enacted as "a compromise between those who favored repeal of the hospital exemption and those who opposed repeal." AHA Br. at 33-34 n.18.

tions. Both of these provisions were derived, verbatim, from language which the California Hospital Association had proposed towards the close of the 1972 Hearings and which the AHA had endorsed. *See* 1972 Hearings at 173-78, 159.[22]

In its testimony in 1973, the hospital industry championed the Taft bill on much the same grounds it had opposed the 1972 bill to extend the NLRA's coverage to hospitals. With respect to the unit proliferation issue, the AHA and its allies continued to define their concern by referring to the NLRB's decisions involving proprietary hospitals and by expressing the fear that, left unchecked, the NLRB would create a large number of small, single-specialty or crafts units in hospitals.[23]

Organized labor vigorously opposed the Taft bill, arguing that it was improper to "establish[] different procedures for nonprofit hospitals than for other business establishments," and that the Labor Board was fully able to develop special rules for the hospital industry which would take account of "the special characteristics which distinguish the hospital industry from other industries" just as the Board had "dealt with that problem in other industries."[24] The Nixon Administration concurred, testifying that

[22] In commentary to its proposal, the California Hospital Association had observed, in explaining the proposal for an office clerical unit, that "the Board does not combine office clericals with other employees if either party objects." 1972 Hearings at 178. The AHA made the same observation in 1973. *See* 1973 Hearings at 148. This is further evidence that in 1972-73 the hospital industry was well aware of the various unit *rules* followed by the NLRB.

[23] 1973 Hearings at 139 (AHA); 160-61 (Iowa Hospital Association); 175 (Colorado Hospital Association); 181 (Texas Hospital Association); 188 (California Hospital Association); 465 (Ohio Hospital Association).

[24] 1973 Hearings at 562, 564 (testimony of Andrew Biemiller Legislative Director of the AFL-CIO); *see also id* at 49, 60, 286.

> In the long run, the only thing that prevents strikes is the establishment and maintenance of a good collective bargaining climate. And we believe that the best way to assure that kind of climate is by covering employees in the private health care field under the NLRA in essentially the same way that employees in other industries are covered. [1973 Hearings at 428; testimony of Undersecretary of Labor Richard Schubert]

With particular regard to the unit determination issue, Undersecretary Schubert added: "We agree that unwise unit determinations could be harmful, but we see no reason to anticipate such action by the Board." *Id.* at 427. The only amendments to the NLRA which the Nixon Administration supported were "limited safeguards" proposed "to assure the greatest participation possible of the Federal Mediation and Conciliation Service." *Id.* at 428-29.[25]

4. When the Senate Labor Committee concluded its hearings in October, 1973, Senator Taft's staff arranged a series of meetings between representatives of the hospital associations and of organized labor. Through those negotiations a "compromise was struck."[26] The hospital

[25] In its brief to this Court, the AHA asserts that the Taft bill "was opposed as overly rigid and unduly restrictive of the Board's flexibility to determine bargaining units on a case-by-case basis taking into account the particular situation at each hospital." AHA Br. at 27. As the quotations in text prove, the AHA's characterization has nothing to do with what the opponents of the Taft bill —both from labor and from the administration—actually said. Indeed, it is noteworthy that the only citation the AHA offers to support its assertion is to a speech by Senator Dominick, who was aligned with the AHA—and not with the Taft bill opponents—in 1973-74.

[26] Pointer, *The 1974 Health Care Amendments to the National Labor Relations Act*, 26 Labor Law. J. 350, 355 (1975). *See also* Leg. Hist. at 91 (Sen. Cranston), 256 (Senator Taft), 288, 387 (Rep. Thompson).

The AHA contends that because the original Taft bill was never voted upon, no inference can be drawn from the fact that the bill

industry gave up its quest for a four-month cooling off period following contract expiration, for mandatory strike votes, and for a statutory restriction on the number of health care bargaining units. In return, organized labor accepted the Nixon Administration's proposed special rules for involving the FMCS in labor disputes in the health care industry.[27] The compromise bill was introduced by Senator Taft as a substitute for his original bill. S. 3088, 93rd Cong., 2d Sess. (1974), Leg. Hist. 462-65.

In addition to the text of the bill itself, the AHA and union negotiators developed what Senator Taft referred to as "agreed-upon . . . report language," Leg. Hist. at 112, which addressed issues not dealt with in the bill itself. Thus, in the Senate Committee Report—right after the section entitled "Provisions of the Bill" which explains the statutory provisions in the compromise bill, *see* S. Rep. 93-766, 93rd Cong., 2d Sess. 3-5, Leg. Hist. 10-12—there is a lengthy additional section, entitled "Effect on Existing Law," which sets forth agreed-upon views as to how the NLRB should apply existing and unamended provisions of the NLRA in health care cases, *see id.* at 5-7, Leg. Hist. at 12-14. The admonition to give "[d]ue consideration . . . to preventing proliferation of bargaining units" is contained in this section of the Report. *Id.* at 5, Leg. Hist. at 12. The exact same words appear in a section of the House Report entitled "Effect on Existing Law—Bargaining Units." H.R. Rep. 93-1051, 93rd Cong., 2d Sess. 6 (1974), Leg. Hist. at 274.[28]

failed of enactment. *See* AHA Br. at 27-28 n.12. But surely it is of note that the proponents of the Taft bill, in order to secure the votes needed to enact any special rules governing the health care industry, traded away the provision of the Taft bill establishing bargaining unit rules.

[27] These rules are now codified in NLRA § 8(d), (g), 29 U.S.C. § 158(d), (g).

[28] The full text of the admonition is reprinted in petitioner's brief at p. 5.

The compromise bill was reported out of the Senate and House Labor Committees without material change. Senator Dominick dissented, stating that while he "appreciate[d] Senator Taft's work as a conciliator," the compromise was nonetheless inadequate. S. Rep. 93-766, *supra*, at 39, Leg. Hist. at 46. In particular, Senator Dominick argued that the unit determination issue "merits specific statutory language" because, in his view, a "hospital should be protected by statute from being placed in a position of continual bargaining with different units." *Id.* at 45, Leg. Hist. at 52.

On the floor of the Senate, Senator Taft attempted to put the best possible face on the compromise. In words that closely paralleled the arguments the AHA had made, Senator Taft observed that hospitals generally are "vulnerable to a multiplicity of bargaining units due to the diversified nature of the medical services provided patients." Leg. Hist. at 113. Senator Taft continued:

> If each professional interest and job classification is permitted to form a separate bargaining unit, numerous administrative and labor relations problems become involved in the delivery of health care. * * * *Health care institutions must not be permitted to go the route of other industries, particularly the construction trades, in this regard.* [Leg. Hist. at 113-14; emphasis added [29]]

[29] The AHA's brief omits the italicized words from its quotation of Senator Taft's speech. *See* AHA Br. at 28-29.

Senator Taft's reference to the construction industry reflected arguments the Ohio Hospital Association had made in the 1972 Hearings:

> Like construction and newspapers, also relatively-labor intensive, hospitals are divided into many high specialized crafts, each of which has a vital role in the team effort. The legislation which you are now considering has contributed to fractionation and multiple craft negotiation in construction and newspapers. [1972 Hearings at 238-39]

The AHA asserts that the hospital industry and Senator Taft cited the construction and newspaper industries as "extreme examples of proliferation," but that this "hardly means that their concerns were limited to avoiding those extremes." AHA Br. at 34. As the review of the legislative materials makes clear, however, at no point in the legislative process did the AHA or its allies hint at any concern other than avoiding single craft or single occupation units. It is therefore not surprising that the AHA is unable to offer a single citation to the legislative record to support its assertion.

B. The Lessons.

1. The most salient point that emerges from the legislative materials is this: in enacting the 1974 Amendments Congress made a quite deliberate decision *not* to legislate with respect to hospital unit determinations but rather to leave unchanged the Board's discretionary authority over unit determinations under NLRA §§ 6 and 9.

The 1974 Congress had before it proposals to amend the NLRA in various respects by adding a series of special rules to govern health care institutions, including a proposal to enact special rules governing health care bargaining unit determinations. Congress in fact enacted two special health care provisions, the "notice-of-contract-expiration" and "notice-of-strike" provisions contained in NLRA §§ 8(d), (g). *See* p. 29 *supra*. But the advocates of the special health care bargaining unit provision *failed* in their effort to secure the enactment of that provision, and their proposal was dropped as part of the compromise which led to the enactment of these notice provisions. Thus, NLRA § 9, the section which establishes the NLRB's authority to determine appropriate bargaining units, was left unchanged.

In this context, the fair inference is precisely the one this Court drew in *Beth Israel Hospital v. NLRB*, *supra*, 437 U.S. at 392, with respect to another claim by hospitals for special NLRA treatment: "We can only infer that Congress was satisfied to rely on the Board to continue to exercise the responsibility to strike the appropriate balance between the interests of hospital employees, patients, and employers." And that inference is especially

strong here because § 9(b) does contain certain other limitations on the Board's discretion in shaping units, thus establishing that "Congress knows how to limit the board's discretion to define collective bargaining units." *NLRB v. Action Automotive Inc., supra*, 469 U.S. at 497. As the Court added in *Action Automotive*: "We are not authorized to bind the Board in ways not mandated by Congress." *Id.*

For this reason alone, the 1974 Amendments cannot be understood to impose any legal obligations upon the Board with respect to unit determination, and can provide no independent basis for overturning the Rule.

2. Although the reasoning of *Beth Israel* is compelling, it is not necessary to rely on an "inference" concerning Congress' intent in deciding the instant case. For regardless of whether the 1974 Congress was satisfied or dissatisfied with the Board's administration of § 9 over the years and regardless of what that Congress may have thought about appropriate hospital bargaining units, the 1974 Congress *did nothing to translate its sentiments into positive law*. And it is only through statutes—and not through expressions of intent divorced from any statutory reference point—that the Legislature can impose legal obligations on an administrative agency such as the NLRB.

This Court has on numerous occasions held that one Congress cannot alter the meaning or effect of a statutory provision duly enacted by a prior Congress merely by expressing dissatisfaction with or a new understanding of the provision; this is true even when the subsequent Congress expresses its views in the course of either reenacting the law, *e.g., Pierce v. Underwood*, 487 U.S. 552, 566-67 (1988), or amending other provisions of the same law, *e.g., United States v. American College of Physicians*, 475 U.S. 834, 846-47 (1986); *Oscar Mayer Co. v. Evans*, 441 U.S. 750, 758 (1979); *Martin Evangelical Lutheran Church v. South Dakota*, 451 U.S. 772, 788 (1981). Most recently, the Court made the point in *Public Employees Retirement System v. Betts*, —— U.S. ——, 57 L.W. 4931 (June 23, 1989), a case which is analytically indistinguishable from the instant case.

Betts involved the interpretation of § 4(f)(2) of the Age Discrimination in Employment Act of 1967, 29 U.S.C. § 623(f)(2) ("ADEA"), the section of that Act which permits employers to make age-based distinctions pursuant to a "bona fide employee benefit plan . . . which is not a subterfuge to evade the purposes of [the ADEA]." In 1978 Congress amended that section by adding the following proviso: "except that . . . no such employee benefit plan shall require or permit the involuntary retirement of any individual because of . . . age." Congress did so in order to overturn the holding of *United Air Lines v. McMann*, 343 U.S. 192 (1977), in which this Court had held that a bona fide pension plan which predated the enactment of the ADEA could not be a "subterfuge" to evade ADEA and that retirements required by such a plan were lawful.

The committee reports accompanying the 1978 ADEA amendment—and the statements of the sponsors of that amendment during the floor debates—expressly condemned *McMann's* reasoning (as well as its result), "'particularly its [*McMann*'s] conclusion that an employee benefit plan which discriminates on the basis of age is protected by section 4(f)(2) because it [the plan] predates the enactment of the ADEA.'" *Betts*, 57 L.W. 4933, *quoting*, 124 Cong. Rec. 7881.

Notwithstanding this explicit congressional criticism of *McMann*, the Court in *Betts* could find "no reason to depart from our holding in *McMann* that the term 'subterfuge' is to be given its ordinary meaning, and that as a result an employee benefit plan adopted prior to enactment of the ADEA cannot be a subterfuge." 57 L.W. at 4933-34:

> The 1978 amendments of the ADEA did not add a definition of the term "subterfuge" or modify the language of § 4(f)(2) in any way, other than by inserting the final clause forbidding mandatory retirement based on age. We have observed on more than one occasion that the interpretation given by one Congress (or a committee or member thereof) to an earlier statute is of little assistance in discerning the meaning of that statute. Congress changed the specific result of *McMann* by adding a final clause to § 4(f)(2), but it did not change the controlling, general language of the statute. *As Congress did not amend the relevant statutory language, we see no reason to depart from our holding in McMann. . .* [57 L.W. at 4933; emphasis added.]

The instant case follows *a fortiori* from *Betts*. In *Betts*, the later Congress had amended the section—indeed the very sentence—of the ADEA at issue in the case. The *Betts* Court nonetheless concluded that to the extent the views of the later Congress went beyond the scope of the amendment which that Congress had enacted, the views were not authoritative guides to interpreting the ADEA.

In this case, the 1974 Congress did not amend any part of NLRA § 9, the statutory provision governing the determination of appropriate bargaining units; indeed, as noted above, that Congress expressly decided *not* to do so. It necessarily follows from *Betts* that the 1974 Congress' views as to the rules the Board should apply in administering § 9—which was enacted more than twenty-five years earlier—carry no weight in ascertaining the scope of the Board's § 9 authority.[30]

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[30] The court below, in concluding that the admonition is authoritative, posited that by "changing the domain of application of section 9(b), the 1974 amendments may have changed its meaning without changing its words." Pet. App. 11a-12a. But that statement begs the very question at issue: whether Congress can change the "meaning" of a preexisting statutory provision without changing the statutory text. *Betts* compels a negative answer to that question.

Indeed, if anything this is the last case in which legislative history alone should be allowed to change the meaning of preexisting law. What the 1974 Amendments did was to apply an existing statute—the NLRA—to a set of employers previously excluded from the Act. Surely in this context if Congress wishes different rules to apply to the newly-covered entities than apply to all other entities it is incumbent upon the legislature to enact those rules into positive law.

3. Our showing to this point establishes that because the admonition represents, at most, views of a "subsequent" Congress which views were not enacted into law, the admonition cannot be said to impose any guiding obligations on the Board. There is yet a further fallacy in the AHA's reliance on the admonition: even if it were a contemporaneous expression of the view of the Congress that enacted § 9, the admonition still would be of no legal weight. For the admonition, by its very terms, relates "not to the meaning of the statute but to the manner in which a legally unconstrained [agency] will behave under [the statute]," and, it is "absurd—indeed lawless—to give legal effect" to such expressions. *Center for Auto Safety v. Peck*, 751 F.2d 1336, 1351 (D.C. Cir. 1985) (Scalia, J.). A brief elaboration of this point is in order.

The starting point for analysis is the recognition that, as Judge Friendly observed, the aim of statutory interpretation is to ascertain "what Congress meant by what it said, rather than . . . what it means *simpliciter*."[31] Legislative history's invaluable contribution is to illuminate the meaning of statutory texts. As Judge Easterbrook has observed it is naive to believe that "words have meanings divorced from their contexts—linguistic, structural, functional, social, historical." *In re Sinclair*, 870 F.2d 1340, 1342 (7th Cir. 1989).[32]

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[31] Friendly, *Mr. Justice Frankfurter and the Reading of Statutes*, in *Benchmarks* 218-19 (1967).

[32] Judge Easterbrook continues:

> To decode words one must frequently reconstruct the legal and political culture of the drafters. Legislative history may be

The admonition which is at issue here, however, does not purport to speak to, or shed any light on, the meaning of the statutory text. Section 9(b) bears quoting again:

> The Board shall decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this Act, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof.

The admonition does not address these words but (at most) states a consideration which Congress wished—but did not mandate—the Board to "consider" in a certain category of cases. The admonition thus may conceivably offer some insight into how (the 1974) Congress "expected . . . the [agency] to behave," but the admonition says nothing about how Congress "required [the agency] to behave through the only means by which it can (as far as the courts are concerned at least) require anything—the enactment of legislation." *Auto Workers v. Donovan*, 746 F.2d 855, 860 (D.C. Cir. 1984) (Scalia, J.). Thus, even if the admonition were a contemporaneous expression of the views of the Congress that enacted § 9(b), the admonition could not aid in the interpretation of the statute or impose independent duties on the Board.

For each of these reasons, then, the admonition provides no basis for overturning the Rule.[33]

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invaluable in revealing the setting of the enactment and the assumptions its authors entertained about how their words would be understood. It may show, too, that words with a denotation "clear" to an outsider are terms of art, with an equally "clear" but different meaning to an insider. . . . These we take to be the points of cases . . . holding that judges may learn from the legislative history even when the text is "clear." Clarity depends on context, which legislative history may illuminate. [870 F.2d at 1342]

[33] We leave it to the NLRB to demonstrate that, if the admonition were authoritative, the Rule fully satisfies any obligations that the admonition could be said to impose. We would add only the following:

1. The AHA's attempt to transform the admonition into a requirement of case-by-case decision-making turns the legislative history on its head. "Proliferation" was a term of art in 1974 referring to the pattern of craft units which prevailed in the construction and newspaper industries and which, because of the state-law and proprietary-hospital decisions, the AHA feared would obtain in the hospital industry as well. To avoid that result, the AHA sought special, industry-wide *rules* which would be responsive to characteristics common to the hospital industry. Those opposing the AHA argued that the Board could develop rules that accommodated the realities of the industry without special statutory provisions. That position prevailed in Congress. There is no way to draw out of this a mandate to proceed without such guiding rules.

2. The AHA's thesis is equally faithless to the political realities that led to the crafting of the admonition. In 1974 AHA abandoned its quest for major NLRA amendments in connection with the legislation covering hospitals to secure, through negotiations with organized labor, limited safeguards regarding strikes. In this context, to read the admonition as the AHA does would transform its mild, agreed-upon words into a legal requirement far more drastic than any of the modest health care rules Congress actually legislated, and would turn the admonition into a victory for the hospital industry far more sweeping and significant than that which the industry won in the areas in which the industry actually secured a legislated provision effecting a statutory change.

[34] The AHA goes further and argues that the Rule is "not supported by substantial evidence." That, of course, is not the test for rules promulgated through informal (notice and comment) rulemaking. *See American Power Institute v. American Electric Power*, 461 U.S. 402, 412 n.7 (1983).

III. THE BOARD DID NOT ACT ARBITRARILY OR CAPRICIOUSLY IN PROMULGATING THE RULE.

As its final contention the AHA repeats the tired refrain of parties displeased by administrative action: the Rule, says the AHA, is "arbitrary and capricious."[34] Specifically, the AHA argues that—notwithstanding its own prior position, *see* pp. 7-8, *supra*—"it was folly for the Board even to try to develop a rule that would designate specific bargaining units in the industry . . . because the great diversity in the industry makes such an approach inherently arbitrary and capricious." AHA Br. at 40.

Insofar as the AHA bases its attack on supposed inconsistencies between the findings underlying the Board's decision to engage in rulemaking and prior findings by the Board, we leave it to the NLRB to demonstrate the errors in the AHA's submission. For our part we, as participants in the rulemaking proceeding, focus on the great mass of evidence that was submitted to justify proceeding by general rule.

1. At the threshold, it is important to bear in mind that the Rule applies not to all health care institutions and not even to all hospitals, but rather only to private acute care hospitals which are not primarily psychiatric hospitals or rehabilitation hospitals. J.A. 259, 261. Even among such hospitals there are, of course, various differences; in the nature of things, as the Board observed, no two institutions are identical in all respects. J.A. 187. The relevant question, however, as the Board correctly stated, is not whether diversity exists but whether that diversity is "sufficiently significant to preclude uniform treatment for purposes of establishing the general contours of appropriate bargaining units for acute care hospitals in all but truly extraordinary facilities." J.A. 57-58.

In approaching that question it is very much to the point that, as Judge Posner observed below, any rule necessarily results in a "loss in individualized justice." Pet. App. 15a. The very essence of a rule is to "make[] one or a few of a mass of particulars legally decisive, ignoring the rest"; doing so avoids "the disadvantages of discretionary justice" and achieves a "gain in certainty, predictability, celerity, and economy" *Id.* "Often the tradeoff is worthwhile." *Id.* And the "decision how much discretion to eliminate from the decisional process is itself a discretionary judgment, entitled to broad judicial deference." *Id.* at 16a.[35]

[35] *See also* Justice Scalia's Holmes lecture, *supra*, 56 U. CHI. L. REV. at 1177-87 (acknowledging that "perfect justice can only be achieved if courts are unconstrained by . . . imperfect generalizations" but arguing that nonetheless "the law of rules [should] be extended as far as the nature of the question allows").

Thus, the dispositive question here is whether the Board reached an arbitrary or capricious conclusion in deciding that the hospitals covered by the Rule are sufficiently alike in terms of their employee groupings so as to justify trading off the opportunity for more "individualized justice" to achieve the justice inherent in adjudicating cognate questions with certainty and predictability. It is to that question that we now turn.

2. The record establishes that the hospitals covered by the Rule share many characteristics in common. Over 95% are general medical and surgical hospitals. Furthermore, the bulk of what these hospitals do is to provide inpatient care in medical, surgicial, pediatric, obstetric, and intensive care units. J.A. 53.

Moreover, the rulemaking record establishes that: in virtually every acute care hospital there are certain discrete functions that must be performed, ranging from maintaining the physical plant to caring for the patients; in the nature of things—and by operation of the various accreditation and licensing laws—these various functions require discrete sets of skills and training; and therefore in virtually every hospital there are a discrete group of employees holding a discrete group of jobs each of which encompasses distinct functions.

Put more concretely, and with specific reference to the Rule at issue here, virtually every hospital employs (or uses the service of): skilled craftsmen to maintain the plant's systems; business office clericals to handle billing and collections; medical technicians to perform paraprofessional patient care functions; registered nurses to provide around-the-clock monitoring and care; and physicians to prescribe and direct the treatment of patients.[36]

[36] The only grouping which the AHA appears to challenge in general terms is the separation of technical employees from skilled

We have already observed with respect to the nonprofessional units permitted by the Rule that the considerations which led the Board to recognize medical technicians, business office clericals, and skilled maintenance craftsmen as appropriate groupings relate to the nature of the tasks those groups perform, and that those considerations are in no sense hospital-specific. *See* pp. 14-15 *supra*. The same is true with respect to the two professional groups the Rule permits to organize separately from all other professionals. With respect to RNs, the Board summarized the rationale for a separate unit as follows:

> The distinct functions and collective bargaining interests of RNs compel the conclusion that a separate RN unit is warranted. RNs are a unique group in that their profession demands continuous interaction with patients. Additionally, because of licensure limitations, other professionals may not perform RN work and vice versa. RNs have a separate labor market, and scheduling issues are more of a concern.
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> The industry has contended that adverse consequences would follow having separate RN units, such

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maintenance employees; the AHA argues that this is "[p]erhaps the most telling example"—of what is unclear—because "many of the factors the Board used to distinguish technical employees from service and maintenance workers . . . were used . . . to distinguish skilled maintenance employees from other service and maintenance workers." AHA Br. at 45.

It is, of course, true, that both medical technicians and skilled craftsmen are distinguishable from the unskilled employees (such as those in hospital kitchens and laundries) in that both technicians and craftsmen require special education, skills, and licenses and each group works apart from the unskilled service and maintenance workers. But technicians and craftsmen are equally distinguishable from each other by virtue of their tasks, training, interests, and markets. *See* pp. 14-15 supra. Thus, the fact that these two groups are allowed separate units is, indeed, a "telling example"—of the Board's commendable sensitivity to the discrete, natural functional groupings that exist in hospitals.

> as strikes, jurisdictional disputes, and proliferation of units. The testimony proffered at the hearings has satisfactorily alleviated any concern we had over these possibilities. [J.A. 116-17]

And with respect to physicians the Board found:

> Doctors have considerably more training than other professionals . . . Doctors have the singular responsibility of directing all other patient care employees . . . [D]octors earn substantially more than other professionals . . . Supervision of doctors is limited and is generally done by other doctors . . . [D]octors have particular interest in bargaining about medical education, malpractice insurance, and input into patient care decisions. They have little interest in the issues of special concern to RNs, such as floating, per diem, uniform allowances, overtime etc, and are outnumbered by nurses at a ratio of at least 15:1. We are concerned that if doctors were forced to be included in the same unit with nurses and other professionals, doctors' interests would be overwhelmed. [J.A. 118-19]

Plainly, then, it is possible to generalize about employee groupings within the hospitals covered by the Rule. Indeed in the course of its own business operations, the AHA has done just that: the AHA has found it useful to publish a book entitled "Hospital Departmental Profiles" providing "capsule descriptions of key hospital departments," AFL-CIO Ex. 11, and a second volume entitled "Health Care Occupation" which contains descriptions of hospital positions grouped by "typical departments in moderate to large health care corporations," International Union of Operating Engineers Ex. 1, p. 2.

3. The rulemaking record proves as well that the generalizations on which the Board relied in promulgating the Rule apply notwithstanding the variations that do exist within the industry, such as differences among hos-

pitals in size, range of services provided and the like.[37] Space does not permit us to review the record evidence with regard to each of the units allowed by the Rule; we thus concentrate on the two units that were the focus of the greatest attention at the rulemaking hearings, RN units and skilled maintenance units.

(a) In finding that RN units are appropriate across the range of acute care hospitals, the Board drew upon a wealth of record evidence. In the course of the rulemaking proceeding, more than fifteen practicing RNs—from hospitals large and small, urban and rural, and everything in between—presented evidence regarding their practices, experiences, and hospitals.[38] In addition, RNs from nine state nurses associations, and from several national unions which represent nurses, testified not only from their own personal experiences as practicing nurses but, moreover, from their experiences in working with and representing nurses at literally hundreds of hospitals of all sizes, shapes, and kinds.[39] And all of this

[37] It is worth noting that, in the course of the rulemaking proceeding, the Board canvassed its own decisions and found virtually no divergence in the results the Board had reached from case to case. For example, prior to adopting a "disparity-of-interests" test the Board found RN units appropriate in 24 of 25 cases; technical units appropriate in 18 of 18 cases; and business office clerical units appropriate in 18 out of 18 cases. J.A. 55-56.

[38] At the Chicago hearing, Jacquie Luoma, Lana Bachus, and Lelani Castro testified, Tr. I: 81-147; in San Francisco, Margaret Schauer, Lois Roth, and Linda Liperi testified, Tr. 3114-32, 3694-3705; and in Washington, the Board heard from Valerie Gonzalez and Ruth Korn, Tr. 4350-72, 4855-93. In addition, the American Nurses Association submitted written testimony from eight RNs working at locations remote from the hearings. *See* Submissions of Rhonda Crump, Wilma Jones, Dana Long, Nancy Pashby, Maryann Roylo, Lora Sharon, Carol Soltis, and Terry Stevens.

[39] *See* D.C. Tr. 50-79 (Karen Ballard, New York Nurses Association), 83-114 (Barbara Lumpkin, Florida Nurses Association); 122-37 (Ann Twomey, Hospital Professionals and Allied Employees of New Jersey); Chi. I. Tr. 46-81 (Karen Patek, Minnesota Nurses Association); Tr. 3102-14 (Marilyn Chow, California Nurses Association), 3576-94 (Kathy Sackman, United Nurses Association for California), 3622-48 (Katherine Schmidt, Oregon Federation of Nurses), 4372-92 (Candice Owley, Chairperson, Federation of Nurses and Health Professionals, AFT), 4674-92 (Sondra Clark, RN Coordinator, National Union of Hospital and Health Care Employees), 4892-4920 (Anna Gilmore, Maine Nurses Association), 4920-68 (Gene Shepard, Ohio Nurses Association).

evidence was buttressed by the testimony of five expert witnesses who have extensively studied the nursing profession throughout the nation.[40]

This evidence establishes that "[i]n every facility that delivers health care," RNs alone serve in round-the-clock shifts (D.C. Tr. 75; Ballard), and are "in constant and continuous contact with acutely ill patients, 24 hours a day, seven days a week," Tr. 3139-40 (Prof. Fine). Moreover, RNs alone are responsible for constantly monitoring patients and ensuring that all physicians' orders are carried out and that diagnostic procedures do not harm the patient. Tr. 4627-30 (Prof. Bullough). "[T]he setting in which a professional nurse practices does not alter the nurse's basic practice." D.C. Tr. 52 (Ballard); *see* Tr. 3135 (Prof. Fine). This is so because the unique duties and responsibilities of RNs are mandated by licensure, accreditation standards, hospital and nursing codes, and public law. *See, e.g.*, D.C. Tr. 55-57 (Ballard); Tr. 3105-07 (Chow); 3119-20 (Schauer); 3140 (Fine); and 4665-66 (Rosen).

The record also establishes that, despite variations among hospitals: (1) RNs uniformly have little functional interaction with non-nurse professionals, *see, e.g.*,

[40] *See* Tr. 3133A-58 (Prof. Ruth Barney Fine, Director of the Graduate Program in Nursing Administration, University of Washington), 3594-3622 (Prof. Faith Reierson, Coordinator of Nursing Programs, Olympic College), 4617-59 (Dr. Bonnie Bullough, Dean of the School of Nursing, State University of New York at Buffalo), 4660-74 (Dr. Sumner Rosen, Professor of Social Policy, Labor Market Analysis, and Labor Management Relations, Columbia University), 5703-04 (Dr. Daniel Cornfield, Associate Professor of Sociology, Vanderbilt University).

WS Foley at 6-9; Tr. 3117-18 (Schauer), 3638-41 (Schmidt), 4387-88 (Owley), but do maintain close contact with each other in patient care, D.C. Tr. 62-63 (Ballard), 89 (Lumpkin), Tr. 3154-55 (Schauer), 3493 (Emanuel), 3680 (Indelicato), 3731-32 (Ratner); (2) RNs uniformly have a separate supervisory structure within hospitals and report to the director of nursing, D.C. Tr. 67-68 (Ballard), Tr. 3197, 3259 (Dauner), 3680 (Indelicato), 3703 (Lipari), 4910 (Gilmore); (3) RNs constitute a distinct labor market so that when they bargain about wages they look to the wages earned by RNs at other hospitals and not at the wages of non-RN nurse professionals, Chi. I Tr. 78-79 (Patek), Tr. 3155-56 (Schauer), 3316-18 (Absalom), 4356 (Gonzalez), 4888 (Korn), 4917-18 (Gilmore), 4959-60 (Shepard); and (4) many bargaining issues are of unique concern to nurses such as staffing levels, nursing practice committees, scheduling, and "clinical ladders" which allow nurses opportunities for advancement, AFL-CIO Ex. 4 at ii; WS Ballard at 11, D.C. Tr. 63 (Ballard), Chi. Tr. I 145-46 (Bachus), Tr. 3109-12 (Chow), 3291 (Absalom).

The evidence establishing these facts was, in the main, produced at the rulemaking hearings by witnesses subject to full cross-examination and rebuttal by the AHA which, along with a variety of state hospital associations, was represented by counsel at each of the 14 days of hearings in this matter. The hospital industry failed to rebut this evidence establishing the separate identity of the RN unit regardless of variations among hospitals.

(b) Much the same is true with respect to the skilled maintenance unit. At the rulemaking hearing, the unions presented record evidence with respect to the characteristics of skilled maintenance employees employed in hundreds of hospitals across the nation, varying in size from 38 beds to nearly 2000 beds; located in large metropolitan areas as well as rural settings; ranging from general acute care hospitals to teaching hospitals

as well as facilities concentrating on such specialties as cancer and children's care. IUOE Exhibit 2 (revised), Tr. Chicago II 305-309, Tr. 5651. Evidence was adduced with respect to hospitals whose skilled maintenance employees have been represented in separate units for varying periods of time ranging from years to decades, and where the skilled maintenance unit is one of many units at the facility as well as where it is the only unit. IUOE Exhibit 2 (revised), D.C. Tr. 158, Tr. Chicago II 179, Tr. 5321.

As the NLRB concluded, regardless of such institutional variables, "the evidence . . . shows that, in virtually all health care facilities which were the subject of testimony at the hearings, skilled maintenance employees constitute a discrete and distinct group of employees." J.A. 147.[41]

Thus, regardless of the facility, the empirical evidence established, and the NLRB found, that: (1) the skilled maintenance employees are the only employees performing the distinct function of operating, maintaining, and repairing the facility's physical plant, D.C. Tr. 150-151,

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[41] The evidence presented with respect to this issue included testimony from several currently-employed hospital skilled maintenance workers, Statement of Samuel Fowler; Tr. 3445-3454 (Vince Carick), 5352-79 (William Jacquin); testimony from no less than 25 business managers for locals of the Operating Engineers, each of whom reported on the hospital skilled maintenance units that their locals represented, Chi. II Tr. 161-82 (Phil Schloop, Michael Kelly and supporting affidavits), Tr. 3433-84 (Robert Fox, Arthur Viat and supporting affidavits), Tr. 5315-52, 5379-5402 (Michael Hach, Vincent Giblin, Tr. 5412-5413 (Reese Hammond and supporting affidavits); testimony from experienced training personnel, Chi. II Tr. 182-189 (Marvin Schwenn), Tr. 5402-5420 (Reese Hammond), Statement of William Denevi; and expert testimony from Dr. Ray Marshall, Professor of Economics at the University of Texas, Tr. 4006-20, as well as other academics and health care experts, Tr. 4994-4995 (Dr. William H. Wilkinson), Tr. 5425-5427, 5454, 5467-5468 (Dr. Carol O'Cleireacain), Tr. 5480-5481, 5493-5494 (Dr. Fred McKinney), Tr. 5697-5702, 5708-5709, 5720 (Dr. Daniel Cornfield).

156 (Lake), Tr. Chicago II 164 (Schloop), Tr. 3448-3450 (Carrick), 3457-3459, 3466, 3476-3477 (Viat), 4010 (Marshall), 4995 (Wilkinson), 5720 (Cornfield), 5318 (Hach), 5354-5360 (Jacquin), 5382-5383 (Giblin), Reese Hammond Exh. 1, pp. 580-623; (2) skilled maintenance employee are in a separate department under separate supervision with limited and inconsequential contact with other employees, D.C. Tr. 156 (Lake), Tr. Chicago II 178, 212-213 (Kelly), 329 (Comer), Tr. 3117 (Schauer), 3448, 3453-3454 (Carrick), Tr. 3457, 3478 (Viat), 4014 (Marshall), 5002 (Dretchan), 5330, 5342, 5354 (Hach), 5360, 5376 (Jacquin), Hammond Exh. 1, pp. 581-590, Fox Exh. 2 (Pelroy, Bushey), Hammond Exh. 12 (Tighe, Chambers, Scadden); (3) skilled maintenance employees neither perform work outside their function, nor are other employees cross-trained or transferred to perform skilled maintenance work, D.C. Tr. 163-165 (Lake); Tr. Chicago II 204-205 (Schloop), 212, 216-217 (Kelly), Tr. 3541-3542 (Gallagher), 4025-4026 (Houston), 4195 (Sokatch), 4268-4269 (Weinrich), 4740-4741, 4753 (Ryan), 5400 (Giblin), 5427, 5467-5468 (O'Cleireacain), 5481 (McKinney), 5603-5604 (Berliner); (4) the labor markets in which skilled maintenance employees are hired and advance are separate from those of other employees, and their levels of wages, skill, and professional employees, D.C. Tr. 144, 154-155, 490 (Lake); Tr. Chicago II 163, 165, 203-205 (Schloop), 177, 216-217 (Kelly), Tr. 3344-3345 (Corbett), 3436-3437 (Fox), 3459-3460 (Viat), 4010, 4012, 4018-4019 (Marshall), 4739-4741, 4753 (Ryan), 4994 (Wilkinson), 5327, 5344-5345 (Hach), 5363-5364, 5374, 5377 (Jacquin), 5384, 5400 (Giblin), 5404-5405, 5409-5412 (Hammond), 5425-5427 (O'Cleireacain), 5454, 5468, 5493 (McKinney), 5603-5604, 5645 (Berliner), 5697-5702, 5708-5709 (Cornfield); IUOE Exh. 4; Hammond Exh. 1; and (5) the bargaining interests of skilled maintenance employees differ substantially from those of other groups of employees regardless of the size, location or specialty of the facility, Tr. Chicago II 164-165, 168-169 (Schloop), 175 (Kelly), 209 (Schwein), Tr. 3465-3467 (Viat), 3730, 3734 (Ratner), 4011 (Marshall), 4492-4493 (Willman), 4698-4699, 4729-4730 (Olson), 4785, 4795-4796 (Muehlenkamp), 5187 (Shea), 5388 (Giblin).

As with the RN unit, the evidence establishing these facts regarding the skilled maintenance unit was produced on the record by witnesses subject to full cross examination, and again the AHA failed to rebut any of the foregoing evidence. The AHA's failure in these regards is indicative of the weakness of its claim that the NLRB acted arbitrarily in promulgating the Rule.

4. Perhaps the best evidence of how little there is to the AHA's "diversity" argument comes from the evidence the AHA cites in an attempt to support its contention.

(a) The AHA first faults the Board for "blithely disregard[ing] hundreds of letters submitted by hospitals detailing their size and workforce structure." AHA Br. at 42. But, as the Agency observed, these were mostly form letters, many of which had spaces for hospital administrators to fill in blanks, and one of which was even submitted without the blanks filled in. J.A. 205. To the extent the comments made substantive points the Board, in the preamble to the final rule, summarized the points, J.A. 207-209 (listing 18 points made in the final round of comments) and responded to these points, *e.g.*, J.A. 218-21 (addressing specific comments cited by the AHA Br. at 42-43 n. 24, as having been disregarded).

Of these hundreds of comments, the AHA notes only one, from the Marshalltown Medical & Surgical Center, which purportedly is inconsistent with the groupings found appropriate by the Board. AHA Br. at 42-43 n. 24. The AHA claims that this comment contains evidence that hospitals "have assigned employees to perform duties across the traditional employment categories." *Id.* But

what the comment in fact says is that at Marshalltown Medical and Surgical Center, "security guards also work the switchboard and do maintenance work." And since *NLRA § 9(b)(3)* requires a separate guards unit that comment hardly undermines the groupings contained in the Rule.

(b) The AHA next contends that "the Board had previously found that small or rural hospitals, given their limited resources, often required that employees perform atypical functions." AHA Br. at 44. But the cases the AHA cites to support this proposition, by the AHA's own description, all involve situations in which the lines between professional and non-professional employees (RNs and LPNs, or technicians and technologists) became blurred. *See* AHA Br. at 44 n.27. Again, however, the professional/non-professional line is one required by *NLRA § 9(b)(3)*, and thus the examples the AHA cites do not undermine the Rule.[42]

(c) Third, the AHA argues that the Board's "assumption[s]" regarding skilled maintenance employees are "untrue at many hospitals where all maintenance workers assist in tasks throughout the hospital, coming in

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[42] Elsewhere in its brief the AHA faults the Board for failing to treat small hospitals differently than large hospitals. *See* AHA Br. at 40 n.22. The Board found, however, that "[t]he vast majority of representatives of both unions and employers appeared to agree that hospital size is not well correlated with integration or division of labor, and opposed a rule differentiating between large and small hospitals." J.A. 162, citing comments from four unions, 40 employers, and two expert witnesses.

The AHA contends that the Board misunderstood its position. But at the rulemaking hearing, the AHA's witness testified that "[i]f anything there is more integration [of employees] in a larger institution that has product line management than there is in a smaller institution that has the more traditional standard of patient care." D.C. Tr. 37 (Stickler).

contact with service workers, and particularly where complex maintenance work is farmed out to independent contractors." AHA Br. at 44 (citing two disparity-of-interest decisions). But the contracts between skilled maintenance employees and other workers is not a factor that sets some hospitals apart; to the contrary, the Board found that throughout the industry "skilled maintenance employees do perform work throughout the hospitals" and "have contact with just about every other employee in a hospital," but the Board concluded that this "brief, limited, and incidental" contact did not render the skilled maintenance unit inappropriate. J.A. 136. And while it is undoubtedly true that hospitals differ significantly as to their use of outside contractors to do complex repairs, that simply means that there will be variations among hospitals as to the *number* and *types* of craftsmen employed (or whether any are employed), but says nothing about the appropriateness of a separate unit for those skilled maintenance workers who are employed by a hospital.[43]

(d) Finally, the AHA asserts that "the assumption that business clerical workers invariably differ from and have little contact with other non-professional employees is belied by the findings in numerous cases." AHA Br. at 44-45. But the *facts* as found in those two cases—including the finding of "geographic separation" which the AHA acknowledges, AHA Br. at 45 n.29, essentially *accord* with the Board's findings in the rulemaking regarding business office clericals; those cases simply reflect the application of a different legal test. And in promulgating the Rule the Board specifically stated that in light of its deeper understanding of the business office operation, "we find it unlikely that we would reach the same result" as was reached in *Baker Hospital*, 279 NLRB 308 (1986). *See* J.A. 159-60.

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[43] Of course, if a hospital employs five or fewer skilled maintenance employees, the Rule by its terms is inapplicable and a unit determination will be made on a case-specific basis.

In sum, the AHA fails to offer even a single instance in which the findings underlying the Rule are inapplicable, or the groupings established by the Rule inappropriate. *A fortiori*, the AHA fails to carry its burden of establishing that the Rule's generalizations are so off-target as to be arbitrary and capricious.

CONCLUSION

For the foregoing reasons, and those stated in the brief of the National Labor Relations Board, the judgment of the court of appeals should be affirmed.

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